

		FOR OHF USE					

LL 1

**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0005637</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>St Joseph Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2000</u> to <u>6/30/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>401 Ninth Street</u> <u>Lacon</u> <u>61540</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Marshall</u>		Officer or Administrator of Provider	
Telephone Number: <u>(309) 246-2175</u> Fax # <u>(309) 246-3609</u>		(Signed) _____ (Date) _____	
IDPA ID Number: <u>0005637</u>		(Type or Print Name) <u>Thomas E. Becher</u>	
Date of Initial License for Current Owners: <u>5 / 7 / 1965</u>		(Title) <u>Administrator</u>	
Type of Ownership:		(Signed) _____ (Date) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		Paid Preparer	
<input checked="" type="checkbox"/> Charitable Corp.		(Print Name and Title) <u>H. Dwayne Richardson</u> <u>Principal</u>	
<input type="checkbox"/> Trust		(Firm Name & Address) <u>CBIZ Business Solutions of St. Louis, Inc.</u> <u>940 West Port Plaza, Suite 210, St. Louis, MO 63146</u>	
IRS Exemption Code _____		(Telephone) <u>(314) 453-9696</u> Fax # <u>(314) 453-0289</u>	
<input type="checkbox"/> PROPRIETARY		MAIL TO: OFFICE OF HEALTH FINANCE	
<input type="checkbox"/> Individual		ILLINOIS DEPARTMENT OF PUBLIC AID	
<input type="checkbox"/> Partnership		201 S. Grand Avenue East	
<input type="checkbox"/> Corporation		Springfield, IL 62763-0001	
<input type="checkbox"/> "Sub-S" Corp.		Phone # (217) 782-1630	
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>H. Dwayne Richardson</u> Telephone Number: <u>(314) 453-9696</u>			

STATE OF ILLINOIS

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Facility Name & ID Number St Joseph Nursing Home# 0005637 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsNOT APPLICABLE

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>93</u>	Intermediate (ICF)	<u>93</u>	<u>33,945</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>33,945</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>17,726</u>	<u>15,110</u>		<u>32,836</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,726</u>	<u>15,110</u>		<u>32,836</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.73%

D. How many bed-hold days during this year were paid by Public Aid?

101 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 5 / 7 / 1965

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary NOT APPLICABLE

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 7/1/00-6/30/01 Fiscal Year: 7/1/00-6/30/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

St Joseph Nursing Home

0005637

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	286,823		25,024	311,847	(28,899)	282,948	(53,549)	229,399		1
2	Food Purchase		197,769		197,769	(18,328)	179,441	(43,852)	135,589		2
3	Housekeeping	88,504	13,055		101,559		101,559		101,559		3
4	Laundry	79,739		14,582	94,321		94,321	(7,175)	87,146		4
5	Heat and Other Utilities			169,069	169,069		169,069	(4,236)	164,833		5
6	Maintenance	57,295		24,598	81,893		81,893		81,893		6
7	Other (specify):*										7
8	TOTAL General Services	512,361	210,824	233,273	956,458	(47,227)	909,231	(108,812)	800,419		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,202,674	61,956	7,130	1,271,760	(3,987)	1,267,773		1,267,773		10
10a	Therapy										10a
11	Activities	89,860	3,683	1,412	94,955		94,955		94,955		11
12	Social Services	84,413	1,577	1,657	87,647		87,647		87,647		12
13	Nurse Aide Training					4,819	4,819		4,819		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,376,947	67,216	10,199	1,454,362	832	1,455,194		1,455,194		16
	C. General Administration										
17	Administrative	119,314			119,314		119,314		119,314		17
18	Directors Fees										18
19	Professional Services			36,965	36,965		36,965		36,965		19
20	Dues, Fees, Subscriptions & Promotions			19,447	19,447		19,447	(7,229)	12,218		20
21	Clerical & General Office Expenses	84,202	7,881	29,806	121,889		121,889	(6,530)	115,359		21
22	Employee Benefits & Payroll Taxes			448,757	448,757	78,050	526,807	(11,294)	515,513		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,540	6,540	(832)	5,708	(432)	5,276		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,510	42,510	(30,823)	11,687	(432)	11,255		26
27	Other (specify):*										27
28	TOTAL General Administration	203,516	7,881	584,025	795,422	46,395	841,817	(25,917)	815,900		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,092,824	285,921	827,497	3,206,242		3,206,242	(134,729)	3,071,513		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

St Joseph Nursing Home

#0005637

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			67,065	67,065		67,065	(9,471)	57,594			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			67,065	67,065		67,065	(9,471)	57,594			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,435	1,435		1,435		1,435			39
40	Barber and Beauty Shops		395	12,871	13,266		13,266		13,266			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,917	50,917		50,917		50,917			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		395	65,223	65,618		65,618		65,618			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,092,824	286,316	959,785	3,338,925		3,338,925	(144,200)	3,194,725			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number St Joseph Nursing Home

0005637

Report Period Beginning: 7/1/2000

Ending: 6/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,348)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,976)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,909)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(538)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(112,208)	VAR		15
16	Personal Expenses (Including Transportation)	(1,554)	21		16
17	Non-Care Related Fees	(2,006)	2		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,229)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(432)	24		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (144,200)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (144,200)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ST. JOSEPH'S NURSING HOME, INC.
SCHEDULE VI, PAGE 5 - ADJUSTMENT DETAIL
YEAR ENDED JUNE 30, 2001

G/L ACCT #	ACCOUNT DESCRIPTION	SCHEDULE VI DESCRIPTION	Sch VI Line # Ref		Sch VI Per CR 6/30/2001	Sch V Line # Ref
805100	VENDING MACHINES	NON-CARE RELATED FEES	17	\$	(2,006)	2
781029	CAFETERIA	NON-PATIENT MEALS	4		(7,348)	2
804100	DISCOUNTS EARNED	DISCS, ALLOWS, REBATES & REFUNDS	11		(538)	2
410049	ADVERTISING & PUBLIC RELATIONS	FUND RAISING, ADVERTISING & PROMO	25		(7,229)	20
410030	CABLE TV	TELE, TV, AUDIO IN PATIENT ROOMS	5		(4,976)	21
350021	EMPLOYEE PURCHASES	PERSONAL EXPENSES (INCL TRANSPORTATION)	16			21
347002	MISC REVENUE	PERSONAL EXPENSES (INCL TRANSPORTATION)	16		(1,554)	21
VARIOUS	FROM C/R PAGE 13	NON-STRAIGHT-LINE DEPRECIATION	9		(7,909)	30
VARIOUS	FROM RECLASS & ADJUST WORKSHEET	NON-CARE RELATED OWNER TRANSACTIONS	15		(112,208)	VARIOUS (SEE SCH V - RECLASSES & ADJUSTMENTS)
350020	CNA TUITION REIMBURSEMENT	OTHER - NURSE AIDE TRAINING REIMBURSEMENT	29		(432)	24
TOTALS				\$	<u>(144,200)</u>	

ST. JOSEPH'S NURSING HOME, INC.
SCHEDULE V, PAGES 3 AND 4 - RECLASSES AND ADJUSTMENTS
YEAR ENDED JUNE 30, 2001

Reclassifications Nurse Aide Training Programs:

Nursing and medical records costs	#####	
(Less): In-house nurse aide trainer wages	(13,987)	Reclass: From Line 16; To Line 13, Schedule V
Nursing and medical records costs, net of in-house trainer wages	<u>1,267,773</u>	
Travel and seminar costs	6,540	
(Less): Nurse aide training supplies and tests	(832)	Reclass: From Line 24; To Line 13, Schedule V
Travel and seminar costs, net of nurse aide training supplies and tests	<u>5,708</u>	
Total Reclassifications for Nurse Aide Training Programs	<u>\$ (4,819)</u>	

Reclassification of Workers' Comp Insurance:

Total insurance-prop. liab. insurance	\$ 42,510	
(Less): Workers' comp portion	(30,823) (A)	Reclass: From Line 26; To Line 22, Schedule V
Insurance, net of workers' comp portion	<u>\$ 11,687</u>	

Patient, Sister and Employee Meals:

		Detail	Subtotals	Percentages
Meals served to Patients:	Patient Days (excl. bed-hold days)	32,836		
	Meals per day	3	98,508	73.56%
Meals provided to Sisters:	Number of Sisters	21		
	Meals per day	3		
	Days per year	365	22,995	17.17%
Meals provided to Employees:	Lunch: Secular portion only	21 * 365	7,665	
	Lunch: Secular portion only	10 * 365	3,650	
	Supper: Secular portion only	3 * 365	1,095	12,410 9.27%
	Total Meals Served		<u>133,913</u>	<u>100.00%</u>

Reclassifications for Employee Meals:

Employee portion of total meals:	Total dietary costs	\$ 311,847	
	Employee percentage	9.27%	
	Employee Portion of Dietary Costs	<u>28,899</u>	Reclass: From Line 1; To Line 22, Schedule V
	Food cost	197,769	
	Employee percentage	0	
	Employee Portion of Food Cost	<u>18,328</u>	Reclass: From Line 2; To Line 22, Schedule V
Total Reclassifications for Employee Meals	<u>\$ 47,227</u>		

Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and food cost:	Dietary cost	\$ 311,847	
	Sisters' percentage	17.17%	
	Sisters' Portion of Dietary Cost	<u>\$ 53,549</u>	Adjustment: To Line 1, Schedule V
	Food cost	\$ 197,769	
	Sisters' percentage	17.17%	
	Sisters' Portion of Food Cost	<u>\$ 33,960</u>	Adjustment: To Line 2, Schedule V

Sisters' portion of building and utilities:

Sisters' portion of building:	Convent (Sisters) Square Footage	2,464	
	Total Square Footage	66,656	
	Convent (Sisters) Offset Percentage	<u>3.70%</u>	
Sisters' portion of utilities:	Heat and Other Utilities	\$ 114,600	
	Sisters' percentage	3.70%	
	Sisters' Portion of Heat and Other Utilities	<u>\$ 4,236</u>	Adjustment: To Line 5, Schedule V

Sisters' portion of building depreciation expense:

Building Depreciation Expense	\$ 42,252	
Sisters' percentage	3.70%	
Sister's Portion of Building Depreciation	<u>\$ 1,562</u>	Adjustment: To Line 30, Schedule V

Sisters' portion of insurance:

Insurance Expense (net of workers' comp)	\$ 11,687	
Sisters' percentage	3.70%	
Sister's Portion of Insurance Expense	<u>\$ 432</u>	Adjustment: To Line 26, Schedule V

Employee Salaries in Sisters' Meals:

Dietary Salaries	\$ 287,025	
Sisters' percentage	17.17%	
Salaries Applicable to Sister's Meals	<u>\$ 49,287</u>	
Total Salaries	#####	
Employee Benefits	448,757	
WC Reclass	30,823 (A)	22.92%
Employee Benefit Adjustment	<u>\$ 11,294</u>	Adjustment: To Line 22, Schedule V

Sisters' Laundry Offset:

Total Laundry Expense	\$ 94,321	
Sisters' percentage	7.61%	
Sisters' Laundry Adjustment	<u>\$ 7,175</u>	Adjustment: To Line 4, Schedule V

Total Adjustments for Sisters' Portion of Costs \$ 112,208

St Joseph Nursing Home

ID# 0005637

Report Period Beginning: 7/1/2000

Ending: 6/30/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph Nursing Home

0005637

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,892)	0	0	0	0	0	0	0	0	0	0	(9,892)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,892)	0	0	0	0	0	0	0	0	0	0	(9,892)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,229)	0	0	0	0	0	0	0	0	0	0	(7,229)	20
21	Clerical & General Office Expenses	(6,530)	0	0	0	0	0	0	0	0	0	0	(6,530)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(13,759)	0	0	0	0	0	0	0	0	0	0	(13,759)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,651)	0	0	0	0	0	0	0	0	0	0	(23,651)	29

Summary B

6/30/2001

[illegible]

Facility Name & ID Number St Joseph Nursing Home# 0005637

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WORKSHEET NOT APPLICABLE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	WORKSHEET NOT APPLICABLE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Joseph Nursing Home# 0005637

Report Period Beginning:

7/1/2000Ending: 12/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	WORKSHEET NOT APPLICABLE				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	NONE						\$		\$			\$	1						
2													2						
3													3						
4													4						
5													5						
	Working Capital																		
6	DAUGHTERS OF ST. FRANCIS												6						
7	OF ASSISI	X		WORKING CAPITAL	NONE	VARIOUS	224,000	204,000		NONE	NONE		7						
8													8						
9	TOTAL Facility Related							\$ 224,000	\$ 204,000			\$	9						
	B. Non-Facility Related*																		
10	NONE												10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related							\$				\$	14						
15	TOTALS (line 9+line14)							\$ 224,000	\$ 204,000			\$ NONE	15						

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **St Joseph Nursing Home**# **0005637** Report Period Beginning: **7/1/2000** Ending: **6/30/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	NONE
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	NONE	8	
	1997	NONE	9	
	1998	NONE	10	
	1999	NONE	11	
	2000	NONE	12	
				FOR OHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME St Joseph Nursing Home COUNTY Marshall
FACILITY IDPH LICENSE NUMBER 0005637
CONTACT PERSON REGARDING THIS REPORT NOT APPLICABLE
TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

	1	2	3	4
	Use	Square Feet	Year Acquired	Cost
1	Owned by Dauaghters			\$
2	St. Francis of Assisi	428,532	1965	25,700
3	TOTALS	428,532		\$ 25,700

Facility Name & ID Number St Joseph Nursing Home

0005637

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1965	1965	\$ 484,023	\$ 10,533	VARIOUS	\$ 7,934	\$ (2,599)	\$ 456,252	4
5	50		1969	1969	898,293	18,672	VARIOUS	15,650	(3,022)	843,520	5
6			1968	1968	451,401		25			451,401	6
7			1986	1986	3,877		12			3,877	7
8			1987	1987	5,840	389	15	389		5,254	8
	Improvement Type**										
9	MISC		1968		6,160		50			6,160	9
10	GARAGE		1972		2,491		50			2,491	10
11	FINISH BASEMENT		1973		6,343		50			6,343	11
12	WINDOW		1974		900		50			900	12
13	INSULATION		1976		21,896		50			21,896	13
14	ROOF		1980		16,049		50			16,049	14
15	MISC REMODELING		1981		7,711		10			7,711	15
16	IDPA AUDIT ADJUSTMENTS		1982		1,290		10			1,290	16
17	IDPA AUDIT ADJUSTMENTS		1983		877		10			877	17
18	IDPA AUDIT ADJUSTMENTS		1984		53,742		VARIOUS			53,742	18
19	IDPA AUDIT ADJUSTMENTS		1985		13,995		15			13,995	19
20	IDPA AUDIT ADJUSTMENTS		1969		28,119		20			28,119	20
21	IDPA AUDIT ADJUSTMENTS		1977		11,869	222	50	222		5,692	21
22	IDPA AUDIT ADJUSTMENTS		1986		94,429	647	VARIOUS	647		92,671	22
23	IDPA AUDIT ADJUSTMENTS		1989		146,038	7,452	VARIOUS	3,707	(3,745)	99,932	23
24	DECORATING		1987		3,285		10			3,285	24
25	PARKING LOT		1988		19,937	1,281	VARIOUS	1,281		18,210	25
26	FIRE ALARM SYSTEM		1990		37,956	1,886	VARIOUS	1,886		22,411	26
27	NEW ROOF		1992		55,787	5,580	10	5,580		52,998	27
28	HOT WATER TANK		1992		3,295	329	10	329		3,131	28
29	BUILDING PAINTING		1993		7,336		5			7,336	29
30	ROOF REPAIRS		1993		434	44	10	44		369	30
31	WATER HEATER		1993		223	15	15	15		127	31
32	BOILER REPAIR		1993		1,415	142	10	142		1,203	32
33	CODE ALERT FIRE SYSTEM		1995		8,559	1,006	VARIOUS	1,006		5,713	33
34	MISC		1997		3,013	603	5	603		2,711	34
35	VINYL FLOOR		1998		4,012	802	5	802		2,005	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	IDPA AUDIT ADJUSTMENT	1985	\$ 1,335	\$	10	\$	\$	\$ 1,335	37
38	CERAMIC FLOOR FOR NEW TUB	1999	107	5	20	5		13	38
39	CARPET ON WALLS	2000	2,668	534	5	534		801	39
40	METAMORA TELPHONE SYSTEM	2000	7,337	734	10	734		1,101	40
41	TOMKAT ROOFING	2001	18,760	938	10	938		938	41
42	HOBERT CORP	2001	1,555	78	10	78		78	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,432,447	\$ 51,892		\$ 42,526	\$ (9,366)	\$ 2,241,937	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 130,399	\$ 14,125	\$ 14,020	\$ (105)		\$ 65,400	71
72	Current Year Purchases	20,715	1,048	1,048				72
73	Fully Depreciated Assets	423,327					423,327	73
74								74
75	TOTALS	\$ 574,441	\$ 15,173	\$ 15,068	\$ (105)		\$ 488,727	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING HOME	CHEVY CAPRICE	1987	\$ 10,289	\$	\$	\$		\$ 10,289	76
77	NURSING HOME	PICK-UP	1995	14,590					14,590	77
78	NURSING HOME	MISC. OTHER	VARIOUS	7,279					7,279	78
79										79
80	TOTALS			\$ 32,158	\$	\$	\$		\$ 32,158	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,064,746	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,065	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,594	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,471)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,762,822	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SISTERS SHARE OF BUILDING	\$ 63,491	\$ 1,562	\$ 60,590	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 63,491	\$ 1,562	\$ 60,590	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WORKSHEET NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>170</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>91</u>
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	
2	Books and Supplies		332		332
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		3,987		3,987
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		500		500
9	TOTALS	\$	\$ 4,819	\$	\$ 4,819
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,819			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number St Joseph Nursing Home

0005637

Report Period Beginning: 7/1/2000

Ending:

6/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2001

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 64,354	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,642)	166,355		3
4	Supply Inventory (priced at Cost)	23,276		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 253,985	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	76,103		13
14	Buildings, at Historical Cost	1,542,375		14
15	Leasehold Improvements, at Historical Cost	208,573		15
16	Equipment, at Historical Cost	1,184,003		16
17	Accumulated Depreciation (book methods)	(2,327,483)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Board-Designated Assets	96,444		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 780,015	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,034,000	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 72,329	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,989		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 158,318	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Motherhouse	204,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 204,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 362,318	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 671,682	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,034,000	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 766,860	1
2	Restatements (describe):		2
3	NONE		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 766,860	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(95,178)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (95,178)	17
	B. Transfers (Itemize):		
18	NONE		18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 671,682	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number St Joseph Nursing Home

0005637

Report Period Beginning: 7/1/2000

Ending:

6/30/2001

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,753,083	1
2	Discounts and Allowances for all Levels	(666,323)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,086,760	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	432	11
12	Gift and Coffee Shop	2,006	12
13	Barber and Beauty Care	18,205	13
14	Non-Patient Meals	7,348	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,101	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,092	23
D. Non-Operating Revenue			
24	Contributions	21,682	24
25	Interest and Other Investment Income***	3,963	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,645	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SISTERS MAINTENANCE	97,250	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 97,250	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,243,747	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	956,458	31
32	Health Care	1,454,362	32
33	General Administration	795,422	33
B. Capital Expense			
34	Ownership	67,065	34
C. Ancillary Expense			
35	Special Cost Centers	14,701	35
36	Provider Participation Fee	50,917	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,338,925	40
41	Income before Income Taxes (line 30 minus line 40)**	(95,178)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (95,178)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number St Joseph Nursing Home# 0005637Report Period Beginning: 7/1/2000Ending: 6/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,464	1,640	\$ 32,815	\$ 20.01	1
2	Assistant Director of Nursing	1,936	2,080	38,040	18.29	2
3	Registered Nurses	14,725	16,151	236,456	14.64	3
4	Licensed Practical Nurses	8,692	9,306	132,381	14.23	4
5	Nurse Aides & Orderlies	56,251	61,157	578,103	9.45	5
6	Nurse Aide Trainees	10,046	10,629	61,650	5.80	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,011	4,503	54,477	12.10	8
9	Activity Director	2,200	2,200	26,335	11.97	9
10	Activity Assistants	6,954	7,906	63,525	8.04	10
11	Social Service Workers	5,578	6,190	69,193	11.18	11
12	Dietician					12
13	Food Service Supervisor	3,652	4,212	59,659	14.16	13
14	Head Cook	8,630	9,494	75,425	7.94	14
15	Cook Helpers/Assistants	6,735	7,311	42,898	5.87	15
16	Dishwashers	13,473	15,166	108,842	7.18	16
17	Maintenance Workers	3,635	4,195	57,295	13.66	17
18	Housekeepers	11,268	12,734	88,504	6.95	18
19	Laundry	10,823	11,846	79,739	6.73	19
20	Administrator	1,988	2,080	78,300	37.64	20
21	Assistant Administrator	1,988	2,080	41,014	19.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,701	8,678	84,202	9.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,063	3,415	35,137	10.29	31
32	Other Health Care(specify)	1,991	2,135	33,614	15.74	32
33	Other(specify)	1,523	1,560	15,220	9.76	33
34	TOTAL (lines 1 - 33)	188,327	206,668	\$ 2,092,824 *	\$ 10.13	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	132	\$ 5,864	1	35
36	Medical Director				36
37	Medical Records Consultant	48	1,958	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	1,200	10	39
40	Physical Therapy Consultant	130	1,980	10	40
41	Occupational Therapy Consultant	52	225	10	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	19	1,768	10	43
44	Activity Consultant	24	1,413	11	44
45	Social Service Consultant	28	1,658	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	601	\$ 16,066		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

ST. JOSEPH NURSING HOME
SCHEDULE XIX, G, PAGE 21 - SCHEDULE OF TRAVEL AND SEMINAR
Year Ended June 30, 2001

SEMINAR NAME	EMPLOYEE(S)	DATE	COST
Occupational Rehab	C. Britton	8/14/2000	\$ 345
Speech Therapy	K. Mullins	10/5/2000	70
36 Hour Activity Prof.	A. Taliani	7/20/2000	475
Alzheimer's Train the Trainer	A. Taliani	8/14/2000	50
Active Treatment	A. Taliani Sr. Agnes Stetson Anita Evans Sandy Bogner	3/17/2001	140
Fact and Fiction	M. Smith	5/11/2001	160
Alzheimer's Training	A. Taliani	6/15/2001	50
C N A Testing	M. Foster J. Kissee	7/27/2000	300
CPR Training	All nursing staff	7/18/2000	66
Alzheimers' Train the Trainer	M. Foster J. Kissee	8/14/2000	200
C N A Instructor Course	J. Kissee	8/14/2000	560
Illinois Nursing Law	M Detrempe B. Hasenjaeger M. Smith	8/24/2000	147
CPR Training	All nursing staff	#####	22
C N A Training	C N A Class	2/15/2001	65
Dietary Mgr. Smart Solutions	J. Hufnagel B. Strong	11/3/2000	130
All Star SellABration	J. Hufnagel B. Strong	3/13/2001	30
Dietary Mgr.CDM Credentialing	D. Hagemeier	5/16/2001	351
Alzheimer's Training	H. Cowell	6/15/2001	50
Communication and Behavior	All staff	7/31/2000	50
Corporate Compliance	T. Becher M. Schlink A. Taliani	7/31/2000	130
UNC - Long Term Care	M. Schlink	10/4/2000	524
OBRA Regulations	All Staff	#####	295
Nursing Administration	C. Bergen T. Becher	#####	130
Heartsaver Plus	C N A Class	1/29/2001	140
Climb Closer to Goals	T. Becher A. Taliani M.Cutler H. Cowell	2/28/2001	260
Daily Challenges	M. Cutler	3/26/2001	65
Total			<u>\$ 4,805</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number <u>St Joseph Nursing Home</u>	STATE OF ILLINOIS # <u>0005637</u>	Report Period Beginning: <u>7/1/2000</u>	Ending: <u>6/30/2001</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
 If YES, give association name and amount. Catholic Health Assoc, AAHSA, Life Services Network, Lacon Chamber of Commerce

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
 What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,806 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 50,917
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? YES-Sisters (no costs) For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 47,227 Has any meal income been offset against related costs? YES Indicate the amount. \$ 7,348

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? NO
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 0%
 d. Have vehicle usage logs been maintained? YES
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? YES
 Firm Name: BALLARD, FOLKINS & NUSSBAUM, LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
 Attach invoices and a summary of services for all architect and appraisal fees.